

Facility Name & ID Number JONESBORO HEALTHCARE CENTER

0043562 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>19</u>	Skilled (SNF)	<u>19</u>	<u>6,954</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,228</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>77</u>	TOTALS	<u>77</u>	<u>28,182</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,253</u>	<u>1,253</u>	8
9	SNF/PED					9
10	ICF	<u>13,849</u>	<u>4,670</u>	<u>915</u>	<u>19,434</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,849</u>	<u>4,670</u>	<u>2,168</u>	<u>20,687</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.41%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 2/7/98 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 19 and days of care provided 1,253

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID NumberJONESBORO HEALTHCARE CENTER#0043562Report Period Beginning:01/01/00Ending:12/31/00Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	78,815	6,153	3,666	88,634		88,634	(30)	88,604			1
2	Food Purchase		99,228		99,228		99,228		99,228			2
3	Housekeeping	47,786	5,096		52,882		52,882		52,882			3
4	Laundry	28,441	3,326	355	32,122		32,122		32,122			4
5	Heat and Other Utilities			55,244	55,244		55,244		55,244			5
6	Maintenance	16,049	4,973	17,065	38,087		38,087		38,087			6
7	Other (specify):*											7
8	TOTAL General Services	171,091	118,776	76,330	366,197		366,197	(30)	366,167			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	441,412	39,645	46,888	527,945		527,945	3,755	531,700			10
10a	Therapy		21	35,574	35,595		35,595		35,595			10a
11	Activities	11,962	872	403	13,237		13,237		13,237			11
12	Social Services	19,211		403	19,614		19,614	45	19,659			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	472,585	40,538	89,868	602,991		602,991	3,800	606,791			16
	C. General Administration											
17	Administrative			79,443	79,443		79,443	13,282	92,725			17
18	Directors Fees											18
19	Professional Services			1,975	1,975		1,975	26,698	28,673			19
20	Dues, Fees, Subscriptions & Promotions			4,083	4,083		4,083	(2,072)	2,011			20
21	Clerical & General Office Expenses	866	6,697	16,502	24,065		24,065	32,646	56,711			21
22	Employee Benefits & Payroll Taxes			209,097	209,097		209,097	58,220	267,317			22
23	Inservice Training & Education											23
24	Travel and Seminar			632	632		632	2,940	3,572			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,274	28,274		28,274	17,775	46,049			26
27	Other (specify):*											27
28	TOTAL General Administration	866	6,697	340,006	347,569		347,569	149,489	497,058			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	644,542	166,011	506,204	1,316,757		1,316,757	153,259	1,470,016			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			56,543	56,543		56,543		56,543			30
31	Amortization of Pre-Op. & Org.			241,194	241,194		241,194	(232,371)	8,823			31
32	Interest			316,941	316,941		316,941		316,941			32
33	Real Estate Taxes			20,160	20,160		20,160		20,160			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,679	8,679		8,679		8,679			35
36	Other (specify):* MTG Guarantee			62,466	62,466		62,466		62,466			36
37	TOTAL Ownership			705,983	705,983		705,983	(232,371)	473,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,881	22,530	37,411		37,411		37,411			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,274	42,274		42,274		42,274			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		14,881	64,804	79,685		79,685		79,685			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	644,542	180,892	1,276,991	2,102,425		2,102,425	(79,112)	2,023,313			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,072)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(241,534)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (243,636)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	164,524	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 164,524		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (79,112)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line
1	OTHER REVENUE	\$ (3,216)	21
2	AMORT - GOODWILL	(232,371)	31
3	BANK CHARGES	(73)	21
4	PRIOR YEAR EXPENSE	(343)	21
5	FINES/PENALTIES	(531)	21
6	EXTRAORDINARY ITEMS	(5,000)	21
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
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76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(241,534)	90

Summary A

12/31/00

[illegible]

Summary B

Facility Name & ID Number

0043562

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		SEE ATTACHED LIST		EDEN & ASSOC, INC	WILSON, WY	CONSULTING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Contract Services - RN	\$	Senior Living Properties, LLC	100.00%	\$ 399	\$ 399	1
2	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	1,534	1,534	2
3	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	1,822	1,822	3
4	V	12	Social Services Consultant	403	Senior Living Properties, LLC	100.00%	448	45	4
5	V	17	Contract Services - Business Office	24,666	Senior Living Properties, LLC	100.00%	33,395	8,729	5
6	V	17	Contract Services - Administrator	54,277	Senior Living Properties, LLC	100.00%	58,830	4,553	6
7	V	24	Travel	632	Senior Living Properties, LLC	100.00%	3,436	2,804	7
8	V	21	Business Meals		Senior Living Properties, LLC	100.00%	252	252	8
9	V	24	Seminars		Senior Living Properties, LLC	100.00%	136	136	9
10	V	21	Office Supplies	1,759	Senior Living Properties, LLC	100.00%	2,132	373	10
11	V	21	Supplies	2,418	Senior Living Properties, LLC	100.00%	2,490	72	11
12	V	21	Postage	2,520	Senior Living Properties, LLC	100.00%	2,534	14	12
13	V	21	Telephone	9,592	Senior Living Properties, LLC	100.00%	10,545	953	13
14	Total			\$ 96,267			\$ 117,953	\$ * 21,686	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	EDP Services	\$	Senior Living Properties, LLC	100.00%	\$ 4,228	\$ 4,228	15
16	V	19	Legal Fees	1,975	Senior Living Properties, LLC	100.00%	11,227	9,252	16
17	V	19	Accounting Fees		Senior Living Properties, LLC	100.00%	17,446	17,446	17
18	V	26	Insurance - General Liability	25,370	Senior Living Properties, LLC	100.00%	28,525	3,155	18
19	V	26	Insurance - Property & Contents	2,704	Senior Living Properties, LLC	100.00%	17,193	14,489	19
20	V	26	Insurance - Other	200	Senior Living Properties, LLC	100.00%	331	131	20
21	V	22	Workers Compensation Claims	155,999	Senior Living Properties, LLC	100.00%	200,379	44,380	21
22	V	22	Health & Dental Insurance		Senior Living Properties, LLC	100.00%	13,840	13,840	22
23	V	21	Management Fees		Senior Living Properties, LLC	100.00%	35,917	35,917	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 186,248			\$ 329,086	\$ * 164,524	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JONESBORO HEALTHCARE CENTER # 0043562 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Senior Living Properties, LLC
 Street Address 3395 North Pines Drive, Suite 102
 City / State / Zip Code Wilson, Wyoming 83014
 Phone Number (307) 739-1209
 Fax Number (307) 739-1217

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL only)	675,434	31	\$ 13,034	\$ 20,687	\$ 399	1
2	10	Contract Services - RN	Resident Days (IL only)	675,434	31	50,078	20,687	1,534	2
3	10	Contract Services - RN	Resident Days (IL only)	675,434	31	59,476	20,687	1,822	3
4	12	Social Services Consultant	Resident Days (IL only)	675,434	31	1,475	20,687	45	4
5	17	Contract Services - Business Office	Resident Days (Total)	1,728,555	88	729,382	20,687	8,729	5
6	17	Contract Services - Administrator	Resident Days (IL only)	675,434	31	148,670	20,687	4,553	6
7	24	Travel	Resident Days (IL only)	675,434	31	91,552	20,687	2,804	7
8	21	Business Meals	Resident Days (IL only)	675,434	31	8,225	20,687	252	8
9	24	Seminars	Resident Days (IL only)	675,434	31	4,452	20,687	136	9
10	21	Office Supplies	Resident Days (IL only)	675,434	31	12,185	20,687	373	10
11	21	Supplies	Resident Days (IL only)	675,434	31	2,350	20,687	72	11
12	21	Postage	Resident Days (IL only)	675,434	31	466	20,687	14	12
13	21	Telephone	Resident Days (IL only)	675,434	31	31,125	20,687	953	13
14	21	EDP Services	Resident Days (IL only)	675,434	31	138,040	20,687	4,228	14
15	19	Legal Fees	Resident Days (Total)	1,728,555	88	737,379	20,687	8,825	15
16	19	Accounting Fees	Resident Days (Total)	1,728,555	88	1,457,713	20,687	17,446	16
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	88	263,635	20,687	3,155	17
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	88	1,210,642	20,687	14,489	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924	20,687	131	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015	20,687	3,950	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469	20,687	13,840	21
22	21	Management Fees	Resident Days (Total)	1,728,555	88	1,721,509	20,687	20,603	22
23	19	Legal Fees	Resident Days (IL only)	675,434	31	13,948	20,687	427	23
24	22	Workers Compensation Claims	Resident Days (IL only)	675,434	31	1,320,062	20,687	40,430	24
25	TOTALS				\$ 9,512,806	\$		\$ 149,210	25

Facility Name & ID Number JONESBORO HEALTHCARE CENTER # 0043562 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Senior Living Properties, LLC
Street Address 3395 North Pines Drive, Suite 102
City / State / Zip Code Wilson, Wyoming 83014
Phone Number (307) 739-1209
Fax Number (307) 739-1217

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Management Fees	Resident Days (IL only)	675,434	31	\$ 500,000	\$	20,687	\$ 15,314	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 500,000	\$		\$ 15,314	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC COMM MORT CORP		X	ACQUISITION	\$22,149.00	2/6/98	\$ 3,159,028	\$ 2,957,204	2/1/08	0.0681	\$ 213,521	1	
2	CCS NOTE		X	ACQUISITION	\$815.00	2/6/98	139,780	139,780	2/7/08	0.0700	28,885	2	
3	SEE ATTACHED		X	ACQUISITION	\$815.00	2/6/98	139,780	139,780	2/7/08	0.0700	28,885	3	
4												4	
5												5	
	Working Capital												
6	HEALTH CARE FINANCIAL PART	X		WORKING CAPITAL	NONE	2/6/98	51,330	59,375	DEMAND	PRIME + 2%	45,650	6	
7												7	
8												8	
9	TOTAL Facility Related				\$23,779.00		\$ 3,489,918	\$ 3,296,139			\$ 316,941	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,489,918	\$ 3,296,139			\$ 316,941	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	13,758	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	20,124	2
3. Under or (over) accrual (line 2 minus line 1).	\$	6,366	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	33,918	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$0 For 192000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	20,160	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	18,468	8
	1996	19,286	9
	1997	19,839	10
	1998	19,642	11
	1999	16,970	12
	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,690

B. General Construction Type: Exterior MASONRY Frame WOOD Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	131,116	1998	\$ 6,500	1
2					2
3	TOTALS	131,116		\$ 6,500	3

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$153,202	\$21,260	\$21,260	\$	VARIOUS	\$56,691	37
38	Current Year Purchases	2,246	150	150		VARIOUS	150	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$155,448	\$21,410	\$21,410	\$		\$56,841	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$1,045,540	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$56,543	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$56,543	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$151,377	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

☒ YES

☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5					NOT APPLICABLE			5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms: NOT APPLICABLE
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 7,270
- Description: DISHWASHER - \$196; COPIER - \$330; SCAFFOLDING TRUCK - \$6,744
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			NOT APPLICABLE		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	\$
13.	/2002	\$
14.	/2003	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts			2,160	11,998		14,158	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ancillary Services	39.2, 39.3					23,253		23,253	13
14	TOTAL			\$		\$ 2,160	\$ 35,251		\$ 37,411	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,936	\$	1
2	Cash-Patient Deposits	19,457		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,276)	211,307		3
4	Supply Inventory (priced at COST)	3,348		4
5	Short-Term Investments			5
6	Prepaid Insurance	(92,085)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 145,963	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,500		13
14	Buildings, at Historical Cost	860,706		14
15	Leasehold Improvements, at Historical Cost	25,344		15
16	Equipment, at Historical Cost	152,990		16
17	Accumulated Depreciation (book methods)	(151,377)		17
18	Deferred Charges	2,043,624		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,937,787	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,083,750	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 581,575	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,457		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,918		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTER CO SLP TEXAS	361,577		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 996,527	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,296,139		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,296,139	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,292,666	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,208,916)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,083,750	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (551,105)	1
2	Restatements (describe):		2
3	AUDIT ADJUSTMENTS	7,019	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (544,086)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(664,830)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (664,830)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,208,916)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,530,266	1
2	Discounts and Allowances for all Levels	(236,005)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,294,261	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,345	6
7	Oxygen	1,966	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 76,311	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	30	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	19,606	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,152	19
20	Radiology and X-Ray		20
21	Other Medical Services	23,019	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 63,807	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER REVENUE	3,216	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,216	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,437,595	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	366,197	31
32	Health Care	602,991	32
33	General Administration	347,569	33
	B. Capital Expense		
34	Ownership	705,983	34
	C. Ancillary Expense		
35	Special Cost Centers	37,411	35
36	Provider Participation Fee	42,274	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,102,425	40
41	Income before Income Taxes (line 30 minus line 40)**	(664,830)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (664,830)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Extended If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,383	10,947	130,777	11.95	3
4	Licensed Practical Nurses	8,533	9,955	108,255	10.87	4
5	Nurse Aides & Orderlies	24,785	28,916	191,509	6.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,508	1,780	11,962	6.72	9
10	Activity Assistants					10
11	Social Service Workers	1,654	1,930	19,211	9.96	11
12	Dietician					12
13	Food Service Supervisor	1,788	2,086	18,750	8.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,451	11,026	60,065	5.45	15
16	Dishwashers					16
17	Maintenance Workers	1,941	2,265	16,049	7.09	17
18	Housekeepers	7,326	8,547	47,786	5.59	18
19	Laundry	4,743	5,534	28,441	5.14	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,734	2,023	11,737	5.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,846	85,008	\$ 644,542 *	\$ 7.58	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 3,666	1.3	35
36	Medical Director	MONTHLY	6,600	9.3	36
37	Medical Records Consultant	MONTHLY	405	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	MONTHLY	35,574	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	403	11.3	44
45	Social Service Consultant	MONTHLY	403	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,051		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$ 200,379	IDPH License Fee	\$
				Unemployment Compensation Insurance		9,087	Advertising: Employee Recruitment	1,359
				FICA Taxes		44,011	Health Care Worker Background Check	
				Employee Health Insurance		13,840	(Indicate # of checks performed)	454
				Employee Meals			PROF DUES/LICENSES	198
				Illinois Municipal Retirement Fund (IMRF)*			ADVERTISING - HELP WANTED	2,071
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	(2,071)
CONTRACT SERV - BUSINESS OFFICE			\$ 24,666				Non-allowable advertising	()
CONTRACT SERV - ADMINISTRATOR			54,777				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 79,443	TOTAL (agree to Schedule V,		\$ 267,317	TOTAL (agree to Sch. V,	\$ 2,011
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
VARIOUS	LEGAL		\$ 1,975			\$	Out-of-State Travel	\$
							In-State Travel	3,572
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,975				line 24, col. 8)	\$ 3,572

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number		JONESBORO HEALTHCARE CENTER		STATE OF ILLINOIS	#	0043562	Report Period Beginning:	01/01/00	Ending:	12/31/00	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>NO</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>NO</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report?										
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity?										
(5)	Have you properly capitalized all major repairs and equipment purchases? <u>YES</u> What was the average life used for new equipment added during this period?			<u>12</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ Line										
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement? <u>NO</u> If YES, give effective date of lease.										
(9)	Are you presently operating under a sublease agreement?			YES		<u>X</u>		NO			
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>42,274</u> This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>YES</u>										
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>NO</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>YES</u> Indicate the amount. \$ <u>30</u>										
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? <u>NO</u> If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$										
	c. What percent of all travel expense relates to transportation of nurses and patients? <u>IMMATERI</u>										
	d. Have vehicle usage logs been maintained? <u>YES</u>										
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>YES</u>										
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>NO - MINOR</u>										
	g. Does the facility transport residents to and from day training? <u>NO</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$										
(17)	Has an audit been performed by an independent certified public accounting firm? <u>NO</u> Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.										
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u>										
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees										